

## § 1001.1701

### § 1001.1701 Billing for services of assistant at surgery during cataract operations.

(a) Circumstance for exclusion. The OIG may exclude a physician whom it determines—

(1) Has knowingly and willfully presented or caused to be presented a claim, or billed an individual enrolled under Part B of the Medicare program (or his or her representative) for:

(i) Services of an assistant at surgery during a cataract operation, or

(ii) Charges that include a charge for an assistant at surgery during a cataract operation;

(2) Has not obtained prior approval for the use of such assistant from the appropriate Utilization and Quality Control Peer Review Organization (PRO) or Medicare carrier; and

(3) Is not the sole community physician or sole source of essential specialized services in the community.

(b) The OIG will take into account access of beneficiaries to physicians' services for which Medicare payment may be made in determining whether to impose an exclusion.

(c) Length of exclusion. (1) In determining the length of an exclusion in accordance with this section, the OIG will consider the following factors—

(i) The number of instances for which claims were submitted or beneficiaries were billed for unapproved use of assistants during cataract operations;

(ii) The amount of the claims or bills presented;

(iii) The circumstances under which the claims or bills were made, including whether the services were medically necessary;

(iv) Whether approval for the use of an assistant was requested from the PRO or carrier;

(v) Whether the physician has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral); and

(vi) The availability of alternative sources of the type of health care items or services furnished by the physician.

(2) The period of exclusion may not exceed 5 years.

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## 42 CFR Ch. V (10–1–99 Edition)

### Subpart D—Waivers and Effect of Exclusion

#### § 1001.1801 Waivers of exclusions.

(a) The OIG has the authority to grant or deny a request from a State health care program that an exclusion from that program be waived with respect to an individual or entity, except that no waiver may be granted with respect to an exclusion under § 1001.101(b). The request must be in writing and from an individual directly responsible for administering the State health care program.

(b) With respect to exclusions under § 1001.101(a), a request from a State health care program for a waiver of the exclusion will only be considered if the individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(c) With respect to exclusions imposed under subpart C of this part, a request for waiver will only be granted if the OIG determines that imposition of the exclusion would not be in the public interest.

(d) If the basis for the waiver ceases to exist, the waiver will be rescinded, and the individual or entity will be excluded for the period remaining on the exclusion, measured from the time the exclusion would have been imposed if the waiver had not been granted.

(e) In the event a waiver is granted, it is applicable only to the program(s) for which waiver is requested.

(f) The decision to grant, deny or rescind a request for a waiver is not subject to administrative or judicial review.

(g) The Inspector General may waive the exclusion of an individual or entity from participation in the Medicare program in conjunction with granting a waiver requested by a State health care program. If a State program waiver is rescinded, the derivative waiver of the exclusion from Medicare is automatically rescinded.

#### § 1001.1901 Scope and effect of exclusion.

(a) *Scope of exclusion.* Exclusions of individuals and entities under this title will be from Medicare, Medicaid and